

YOUTH & LITERACY SERVICES APPLICATION



Please print your responses to the following questions and send completed application via email to **bossinfo@cobbworks.org**. If you are unable to print, you can contact our office at 770-528-4300.

Applicant Name First M.I. Last		Social Security Number - -	
Birth Date (mm/dd/yy) / /		Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Guardian/Other Contact Name		Guardian/Other Contact Work Number: () /fax ()	
Home Phone: ()	Cell Phone ()	Email Address:	
Mailing Address:	City	State	Zip code
Home Address	City	State	Zip code
Someone with whom we can leave a message that does not live with you. Name: Phone:		Living Situation: <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless <input type="checkbox"/> Temporary	
Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you are not a US Citizen, please complete: Permanent Resident Card #: _____ Exp. Date ____/____/____	
Race (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Bi-racial/other			

ELIGIBILITY INFORMATION		
Are you a Cobb County resident?	<input type="checkbox"/> YES	<input type="checkbox"/> No
Do you have a disability or an Individual Education Plan (IEP)	<input type="checkbox"/> YES	<input type="checkbox"/> No
Does anyone in your household receive any of the following: <input type="checkbox"/> SS Benefits <input type="checkbox"/> Food Stamps <input type="checkbox"/> TANF <input type="checkbox"/> Free/Reduced Lunch <input type="checkbox"/> Pell Grant		
Are you between the ages of 16-24? Please answer the following questions:		
Are you behind one or more grade levels in school? (if applicable)	<input type="checkbox"/> YES	<input type="checkbox"/> No
Do you have a misdemeanor or felony conviction?	<input type="checkbox"/> YES	<input type="checkbox"/> No
Do you have a High School Diploma or GED?	<input type="checkbox"/> YES	<input type="checkbox"/> No
Are you a runaway youth and/or homeless?	<input type="checkbox"/> YES	<input type="checkbox"/> No
Are you pregnant or parenting a child?	<input type="checkbox"/> YES	<input type="checkbox"/> No
Are you currently in <u>or</u> have ever been in foster care?	<input type="checkbox"/> YES	<input type="checkbox"/> No
Do you need assistance in completing an educational program or securing and retaining a job?	<input type="checkbox"/> YES	<input type="checkbox"/> No
OFFICE USE ONLY		
High Poverty Census Track: _____	% Below Poverty Level _____	
Staff Signature _____	Date _____	

EDUCATION AND WORK HISTORY			
Highest grade level completed:			
School currently attending or last school attended:			
Anticipated date of HS graduation or GED attainment:			
Secondary education completed (if applicable):		<input type="checkbox"/> High school diploma <input type="checkbox"/> GED	
Educational Goals:			
<input type="checkbox"/> Fluency in English <input type="checkbox"/> GED <input type="checkbox"/> Technical Degree or Certification <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Improved Employment <input type="checkbox"/> Other Graduate Degree			
Are you a veteran?			<input type="checkbox"/> YES <input type="checkbox"/> No
I am a male registered with the Selective Service			<input type="checkbox"/> YES <input type="checkbox"/> No
I am authorized to work in the United States			<input type="checkbox"/> YES <input type="checkbox"/> No

Name of Employer		Type of Business	
Address	City	State	Zip code
Dates Employed From (month/year - to (month/year)		Title	
Name and Title of Supervisor		Telephone Number ()	
May we Contact		Type of Employment <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time	
Brief description of duties:			
Reason for leaving:		Last Salary: \$ <input type="text"/> Per <input type="text"/>	

CERTIFICATION AND ACKNOWLEDGEMENT (Please read the following statement carefully)

I hereby affirm that the information provided on this application is true and complete to the best of my knowledge. I also agree that falsified information or significant omissions may disqualify me from further consideration for WIOA/CSBG program activities and may be considered justification for dismissal if discovered at a later date.

I further understand that if information presented is determined to be false or contain omissions, I will be held responsible for repayment of any funds paid to me or for services on my behalf.

Finally, I recognize that an application and eligibility determination are initial steps and do not guarantee program participation.

Applicant Signature

Date

Parent/Guardian Signature
(Required if applicant is under 18 years of age)

Date

Authorized Staff Signature (if applicable)

Date

Applicant Name: _____ **Social Security #:** _____

Income Period: From: _____ To: _____ (Application Date)
 (The income review period includes the last six months of paystubs)

Family Composition:

-17 and under, list all household members and dependents

-18 and up list yourself and dependents ONLY

Family Member	Name	Relationship	Social Security #	Age	Copies of last 6 months of Income (as applicable)
1.		(self/applicant)			<input type="checkbox"/>
2.					<input type="checkbox"/>
3.					<input type="checkbox"/>
4.					<input type="checkbox"/>
5.					<input type="checkbox"/>
6.					<input type="checkbox"/>

Certification:	I attest that to the best of my knowledge the information above is true and correct.	
	Applicant Signature	Date
	Parent/Guardian Signature (Required if applicant is under 18 years of age)	Date

Family income calculations include the following:	Family income calculations exclude the following:
<ul style="list-style-type: none"> • Money, wages and salaries before any deductions (gross) • Net receipts from nonfarm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses) • Net receipts from farm self-employment (receipts from a farm which one operates as owner, renter or sharecropper, after deductions for farm operating expenses) • Social security disability income (SSDI) • Regular payments from railroad retirement, strike benefits from union funds, workers' compensation and training stipends • Alimony • Military family allotments or other regular support from an absent family member or someone not living in the household • Pensions, whether private or government employee (including military retirement pay) • Regular insurance or annuity payments • College or university grants, fellowships and assistantships (see exclusion for needs-based scholarship assistance) • Net gambling or lottery winnings 	<ul style="list-style-type: none"> • Unemployment compensation • Child support payments • Foster care payments • Public Assistance payments (TANF, SSI, RCA, GA) • Old age and survivors' insurance benefits • Financial assistance under Title IV of the Higher Education Act (i.e., Pell Grants, Federal Supplemental Educational Opportunity Grants, Federal Work Study) • Needs-based scholarship assistance • Income earned while a veteran was on active military duty and certain other veterans' benefits (see policy for exclusions) • Capital gains • Any assets drawn down as withdrawals from a bank, the sale of a property, a house or a car • Tax refunds, gifts, loans, lump sum inheritances, one-time insurance payments or other compensation for injury • Noncash benefits such as employer-paid fringe benefits, food or housing received in lieu of wages, Medicare, Medicaid, food stamps, school meals and housing assistance

OFFICE USE ONLY			
Income Review:	Family Size:	Income Limit:	Total Six Months of Income:
Staff Signature:			Eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO

WORKSOURCE COBB YOUNG ADULT PROGRAM
Employment and Income Verification



SECTION I: Instructions to Employer

The information requested below, about employment; is required of applicants to determine eligibility for WIOA services provided through WorkSource Cobb. Please provide the requested information regarding employment and earnings for this individual listed in Section II **for the six (6) months immediately preceding the date of this request.** When completed, **please email to bossinfo@cobbworks.org.** Thank you for your assistance.

Name of Company: _____ Phone: _____

Dates Employed: _____ to _____
Begin Date End Date

Pay Rate: _____ per _____
Amount Hour/Month/Year

Gross Wages Earned
During the preceding six (6) months: \$ _____ to _____
Amount Date Date

Position Title: _____

Employer Representative Name _____ Employer Phone # _____ Date _____

SECTION II: Instructions to Applicant/Applicant's Parent/Guardian

A separate form must be completed for each person in the home who has been employed within the last six (6) months. If you worked for different employers during the past six (6) months, use a separate form for each. Complete the following information in this section to be used by the employer's representative when completing this form.

Employee Name: _____

Employee SS#: _____ DOB: _____

Employee Signature: _____ Date of Request: _____

**The date of the request should be the same as the application date.*

SECTION III: Applicant Authorization to Release Information (To be completed by applicant)

I hereby authorize the release, reporting, and/or confirmation of the information requested above. I understand this information is necessary to determine eligibility for programs and/or services administered by WorkSource Cobb. I further authorize the staff of WorkSource Cobb, its subcontractors, or authorized representatives to obtain additional verbal or written information, if necessary. This authorization shall remain valid for two (2) years from the date of my signature. I understand all information released to WorkSource Cobb will be confidential and will not be released by WorkSource Cobb without my written consent. I agree that a photocopy or facsimile transmission is as valid as the original.

Applicant Name (Printed) _____ Signature _____

Applicant Social Security #: _____ Date of Birth: _____

Parent/Guardian Name (Signature) _____ Date Signed _____
(Required if Applicant is not 18 years or older)

I hereby request and authorize staff, subcontractors, and/or authorized representatives of WorkSource Cobb Workforce Development Board to: ☐ Obtain from ☐ Release to

Institution of Organization Name

Address

City

State

Zip Code

The following type(s) of information from my records (and any specific portion thereof)

- ☐ Attendance Records
- ☐ Progress and Performance Reports
- ☐ Transcripts
- ☐ Certifications
- ☐ Individual Education Plans
- ☐ Pay Stubs
- ☐ Financial Aid Information
- ☐ Employment Information
- ☐ Other _____

Further, I authorize said persons to obtain job title, wage and benefit, hours, and other data relevant to my training under the Workforce Innovation and Opportunity Act (WIOA) from my past or future employers. I understand that this information is necessary for statistical and reporting purposes by WorkSource Cobb. All information I hereby authorize to be obtained by WorkSource Cobb will be held strictly confidential and cannot be released by WorkSource Cobb/CobbWorks without my written consent.

WIOA Customer Signature

Date

Signature of Parent or Authorized Representative, where applicable

Date

WIOA Customer Name Printed

Signature of Witness

Date

Printed Name of Witness

The undersigned and his/her parent or legal guardian, if the participant is under the age of 18 years, do hereby execute this release, waiver and indemnification for himself/herself and his/her heirs, successors, representatives and assigns, and hereby agree and represent as follows:

The release of WorkSource Cobb/CobbWorks, Inc., its volunteers and officers, board members, employees and agents from any and all liability, loss, damage, costs, claims or causes of action including, but not limited to all bodily injuries and property damages arising out of the sole negligence of WorkSource Cobb/CobbWorks, Inc., and/or its affiliates.

I grant to WorkSource Cobb/CobbWorks, Inc. and its designated officers, employees, agents, or contractors the right to take photographs of me and my property in connection with the above-identified subject. I authorize WorkSource Cobb/CobbWorks, Inc. and its assigns and transferees to copyright, use and publish the same in print and/or electronically. I understand that WorkSource Cobb/CobbWorks, Inc. is a non-profit organization and will not generate profits from the use of my photograph. I understand my participation in being photographed is voluntary and I will not be compensated financially for my participation.

I agree that WorkSource Cobb/CobbWorks, Inc. may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. I have read and understand the above:

 Participant Signature

 Date

 Participant Name

 Parent/Guardian Signature
(If participant is under 18)

 Date

 Parent/Guardian Name

 Address

 City

 State

 Zip Code

 Witness Signature

 Printed Name

SHADED AREA FOR OFFICE USE ONLY

Submitted By: _____

Subject Matter: _____

IDENTIFYING INFORMATION	
Applicant's Name:	SSN Last 4 Digits:
COVID-19 IMPACT	
<p>Check all that apply:</p> <p><input type="checkbox"/> Received Free/Reduced Lunch as a result of COVID-19</p> <p><input type="checkbox"/> Parent/Guardian received P-EBT during COVID-19</p> <p><input type="checkbox"/> Experienced a reduction in hours and/or pay due to COVID-19</p> <p><input type="checkbox"/> Experienced one of the following due to COVID-19 related reasons:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Subject to quarantine. <input type="checkbox"/> Caregiver for someone who is subject to quarantine or higher risk. <input type="checkbox"/> Need to care for children or siblings because of school closure or closure of other child care provider. <input type="checkbox"/> At higher risk of getting seriously ill from COVID-19, or lives with someone at higher risk, as outlined by the CDC <input type="checkbox"/> Forced to relocate due to COVID-19. <input type="checkbox"/> N/A <p><input type="checkbox"/> Other: _____</p>	
Applicant Signature	
<p>I hereby certify under penalty of perjury that the information above is true and correct to the best of my knowledge.</p>	
Applicant Signature:	Date:
Parent/Guardian Signature:	Date: